Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DOCTORS HOSPITAL OF LAREDO
3255 WEST PIONEER PKWY
ARLINGTON TEXAS 76013

Respondent Name
EMPLOYERS ASSURANCE CO

Carrier's Austin Representative Box
Box Number 34

MFDR Tracking Number
M4-08-1662-01

MFDR Date Received
October 29, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to our records, we received an initail [sic] payment of $126.00, but there is still an outstanding balance due. Per the Medicare Fee Schedule allowable at 125% the outstanding balance still due for this claim is $232.91."

Amount in Dispute: $232.91

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requester improperly submitted the request for dispute resolution BEFORE the Carrier had the opportunity to take final action. The requester appears to have only billed for one date of service 07/02/07. The requester did not provide an itemization as required per DWC Rule 133.210. The requester is not due additional reimbursement for code 97010 as reimbursement is bundled into payment for other services. Based on the notes provided in the packet and the bill for 07/02/07, this Carrier paid an additional 1 unit US (97035), 1 unit interferential therapy (97032), and 1 unit gait training (97116)."

Response Submitted by: AM Comp

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 2, 2007 – July 30, 2007	97010-GP, 97032-GP, 97035-GP, 97110-GP and 97116-GP	$232.91	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401 sets out the outpatient facility fee guidelines.
3. 28 Texas Administrative Code §134.1, effective May 16, 2002, requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 23, 2007

   - 50 – These are non-covered services because this is not deemed a medical necessity by the payer, payment denied based on medical payment policy.
   - W1 – Workers Compensation State Fee Schedule adjustment. The usual treatment session provided in the home or office settings is 45 to 60 minutes. The medical necessity of services for an unusual length of time must be documented.
   - W10 – No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology reduced to fair and reasonable.

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. Did the requestor submit documentation to support fair and reasonable reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. This dispute relates to physical therapy/occupation therapy provided in an outpatient facility setting. The requestor has listed 07/02/2007 through 07/30/2007 as the dates of service in dispute.
2. The requestor seeks reimbursement for following physical therapy services:
   - 97010-GP (4 units), 97032-GP (4 units), 97035-GP (4 units), 97110-GP (6 units), and 97116-GP (2 units)
   - Procedure code 97032-GP (4 units) electrical stimulation (manual), each 15 minutes
   - Procedure code 97035-GP (4 units) ultrasound, each 15 minutes
   - Procedure code 97110-GP (6 units) therapeutic exercises to develop strength and endurance, range of motion and flexibility
   - Procedure code 97116-GP (2 units) gait training (includes stair climbing)
3. This dispute relates to outpatient physical therapy services provided in a hospital setting with reimbursement subject to the provisions of former Division rule at 28 TAC §134.401(a) (3), effective August 1, 1997, 22 TexReg 6264, which states that "Services such as outpatient physical therapy, radiological studies and laboratory studies are not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific services."
4. Division rule at 28 TAC §134.1, effective May 2, 2006, 31 TexReg 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
6. Former 28 Texas Administrative Code §133.307(c)(2)(G) , effective December 31, 2006, and applicable to disputes filed on or after January 15, 2007, 31 TexReg 10314, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable..." Review of the submitted documentation finds that:

- The requestor billed CPT codes 97010-GP (4 units), 97032-GP (4 units), 97035-GP (4 units), 97110-GP (6 units), and 97116-GP (2 units) on 07/02/2007 through 07/30/2007.
- Per 28 TAC §134.401(a) (3), the CPT codes identified do not have an assigned value.
- Division rule at 28 TAC §134.1, effective May 16, 2002 requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.
- The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for CPT codes 97010-GP (4 units), 97032-GP (4 units), 97035-GP (4 units), 97110-GP (6 units), and 97116-GP (2 units).
- Documentation of the comparison of charges to other carriers was not presented for review.
- Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Payment cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 12, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.